MISSISSIPPI TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

I. Cost Findings and Cost Reporting

A. Each Mississippi hospital participating in the Mississippi Medicaid Hospital Program will submit a Uniform Cost Report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) calendar months after the close of its cost reporting year. No extensions will be granted. All other filing requirements shall be the same as those for Title XVIII. One (1) complete copy of the cost report shall be submitted to the Division of Medicaid (DOM). The cost reports for periods ending in the prior calendar year will be used to calculate the per diem rates for the following October 1 - September 30 fiscal year. For example, the cost report of a hospital with a June 30, 1996 year end would be used to set the rate effective October 1, 1997 through September 30, 1998.

B. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII.

C. Costs reports used to initiate this plan will be for reporting periods beginning April 1, 1980, or earlier.

D. All hospitals are required to detail their costs reports for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals must adhere to the requirements of Section 2414.1; Provider Reimbursement Manual.

E. The cost report must be prepared in accordance with the methods of reimbursement and cost finding in accordance with Title XVIII (Medicare) Principles of Reimbursement except where further interpreted by the Provider Reimbursement Manual or as modified by this plan.

F. Cost reports that are not postmarked by the specified due date, unless a waiver by the Division of Medicaid, Office of the Governor, is granted, will result in a penalty of $50.00 per day the cost report is delinquent. Cost reports with a due date that falls on Saturday, Sunday, a State of Mississippi holiday or a federal holiday will be due the next business day.

A hospital which does not file a cost report within six (6) calendar months after the close of its reporting period may be subject to cancellation of its Provider Agreement at the discretion of the Division of Medicaid, Office of the Governor.

G. A hospital which voluntarily or involuntarily ceases to participate in the Mississippi Medicaid Program or experiences a change of ownership must file a cost report in accordance with Section 2414.2, Provider Reimbursement Manual.

H. All hospitals are required to maintain financial and statistical records. All records must be available upon demand to representatives, employees or contractors of the Division of Medicaid, Office of the Governor, Mississippi State Department of Audit, General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS).

I. Records of related organizations as defined by 42 CFR 405.427 must be available upon demand to representatives, employees or contractors of the Division of Medicaid, MS State Department of Audit, GAO, Medicaid Fraud Control Unit, United States Attorney General's Office or HHS.

J. The Division of Medicaid shall retail all uniform cost reports submitted for a period of at least five (5) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 431.17 and in accordance with Mississippi State Law. Access to submitted cost reports will be in conformity with Mississippi statues and the Division of Medicaid policy.

II. Audits

A. Background

The Division of Medicaid will periodically audit the financial and statistical records of participating providers. The hospital common audit program was established to reduce the cost of auditing costs reports submitted under Medicare (Title XVIII) and Medicaid (Title XIX) and to avoid duplicating audit effort. The purpose is to have one audit of a participating hospital which will serve the needs of all participating programs reimbursing the hospital for services rendered.

B. Common Audit Program

The Division of Medicaid has entered into agreements with Medicare intermediaries for participation in a common audit program of Titles XVIII and XIX. Under this agreement, the intermediaries for participation in a common audit program shall provide DOM the results of the field audits of those hospitals located in Mississippi. DOM will prepare desk reviews based on these field audits. DOM will adjust the prospective rate paid to in-state hospitals based on these desk reviews and field audits.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreements with Medicare intermediaries, DOM shall be responsible for performance of the desk reviews, field reviews and field audits in accordance with Title XVIII standards. On-site audits will be made when desk reviews indicate such are needed.

D. Retention

All audit reports received form Medicare intermediaries or issued by Medicaid will be kept for a period of at least five (5) years following the date all audit findings are resolved.

E. Overpayments/Underpayments

Overpayments as a result of an error or misrepresentation will be reimbursable to Medicaid within sixty (60) days of the date of notification to the provider of the amount due. Underpayments, likewise determined, will be reimbursable to the provider.

III. Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.5 - 413.178 (excluding the inpatient routine salary cost differential) and the guidelines in the Provider Reimbursement Manual; except as modified by Title XIX of the Act and this plan.

A. Title XIX reimbursement will not recognize the above average cost of inpatient routine nursing care furnished to aged, pediatric, and maternity patients. The inpatient routine nursing salary cost differential reimbursed by the Title XVIII program will reduce the reasonable cost for determining Title XIX reimbursement as required in the applicable HCFA cost reporting forms.

B. Section 413.35 Limitations on Coverage of Costs: Charges to Beneficiaries if Cost Limits are Applied to Services - This section will not be applicable to inpatient hospital services rendered to Title XIX beneficiaries so as to prevent a form of supplementation reimbursement. However, Section 413.30 Limitations on Reimbursable Costs will be applied for determining Title XIX reimbursement.

C. All items of expense may be included which hospitals must incur in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 and 42 CFR 440.140 in order to meet the requirements of Sections 1902 (a) (13) and (20) of the Social Security Act;

2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610; and,

3. Any other requirements for the licensing under the State Law which are necessary for providing hospital inpatient services.

D. Implicit in any definition of allowable costs is that those costs should not exceed what a prudent and cost conscious buyer pays for a given service or item. If costs are determined to exceed the level that a prudent buyer would incur, then excess costs would not be reimbursable under the plan. Such cost is allowable to the extent that it is related to patient care, is necessary and proper, and is not in excess of what would be incurred by a prudent buyer.

E. THIS SECTION IS OMITTED.

F. Hospital inpatient general routine operating costs shall be the lesser of actual costs incurred or the limits established by HHS and set forth in 42 CFR 405.460.

G. A hospital may at times offer to the public new or expanded services, purchase equipment, drop such services, or retire equipment which requires Certificate of Need (CON) approval. Within thirty (30) days of implementing a CON approved change, the hospital must submit to MMC an allocation of the approved amount to the Medicaid Program. This amount must be separated as applicable between capital costs, educational costs and operating costs. An estimate of any increase or decrease in operating costs applicable to the Medicaid Program due to the change, as well as, the effective date of the change will also be submitted. Such amounts will be subject to desk review and audit by MMC. Allowance for such changes shall be made to the hospital's Medicaid Prospective rate as provided elsewhere in this plan. Failure to submit such required information within thirty (30) days will be a basis for disallowance of all expenses associated with the change. Overpayments as a result of the differences between estimates and actual costs shall be refunded to MMC.

H. Class ceilings and individual providers reimbursement rates will not include amounts representing growth allowances, profits or efficiency bonuses.

I. Amounts paid to a provider under this plan shall not exceed charges.

J. Payment classes and class ceilings will be established prospectively based on groupings of hospitals by the number of total beds available.

K. The prospectively determined individual hospital's rate may be adjusted under certain circumstances, which are:

1. Administrative errors on the part of the Commission or the facilities may result in erroneous payments. These errors most commonly result from: failure to report a death, discharge, or

transfer; system error in patient classification; and miscalculated payments. Overpayments or underpayments resulting from these errors will be corrected when discovered. Overpayments will be recouped by the Division of Medicaid and underpayments will be reimbursed to the facility. Payment adjustments will not be made for administrative error or audit findings prior to notifying the appropriate facility and affording the facility an opportunity to present facts and evidence to dispute the exception.

2. The hospital corrects a previously submitted cost report. Such corrections must be submitted prior to the end of the current rate period. If an increase or decrease in a rate results, any adjustment shall be made retroactive to the effective date of the original rate.

3. The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. At the discretion of the Division of Medicaid, this shall be grounds to suspend the hospital from the Mississippi Medicaid program until such time as an administrative hearing is held, if requested by the hospital.

4. Appeal decisions are made to the Division of Medicaid as provided by Section IV of this plan.

5. Disproportionate Share Hospitals

   A. A hospital is deemed to be a disproportionate share hospital if the criteria listed below are met.

      (1) For purposes of this paragraph, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under an approved Medicaid State Plan in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(a) the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for in-state (located in Mississippi) hospitals receiving Medicaid payments in Mississippi; or

(b) the hospital's Medicaid inpatient utilization rate is at least the mean Medicaid inpatient utilization rate for in-state (located in Mississippi) hospitals receiving Medicaid payments in Mississippi; or

(2) the hospital's low-income utilization rate exceeds twenty-five percent (25%). For purposes of this paragraph, the term "low-income utilization rate" means, for a hospital, the sum of:

(a) a fraction (expressed as a percentage) the numerator of which is the sum (for a period) of the total revenues paid the hospital for patient services under this State Plan and the amount of the cash subsidies for patient services received directly from State and local governments, and

the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(b) a fraction (expressed as a percentage) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies for patient services received directly from State and local governments. The total charges attributable to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan); and

the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

(3) Additional requirements to be deemed a Disproportionate Share Hospital

(a) Except as provided in paragraph (b), below, no hospital may be defined or deemed as a disproportionate share hospital for Medicaid unless the hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid under an approved State Plan. In the case of a hospital located in a rural area (an area located outside of a Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

(b) Paragraph (a), above, shall not apply to a hospital

(i) the inpatients of which are predominantly individuals under eighteen (18) years of age; or

(ii) which did not offer non-emergency obstetric services as of December 21, 1987.

(c) No hospital may be defined or deemed as a disproportionate share hospital under this State Plan unless the hospital has a Medicaid inpatient utilization rate of not less than one percent (1%).

B. Computation of Disproportionate Share Payments

(1) High Disproportionate Share Hospitals

(a) A hospital is a "high disproportionate share hospital" if the hospital is owned or operated by the State of Mississippi or a unit of government within the State of Mississippi and